Booneville Human Development Center
Death Investigation
January 2016
Acknowledgements

Disability Rights Arkansas, Inc. (DRA) is the federally authorized and funded Protection and Advocacy System and Client Assistance Program for individuals with disabilities in Arkansas. DRA is authorized to protect the human, civil, and legal rights of all Arkansans with disabilities consistent with federal law.

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Executive Summary

In January 2015, Disability Rights Arkansas, Inc. (DRA) issued a report concerning the Booneville Human Development Center (HDC), a state owned and operated ICF/IID at which approximately 121 individuals with developmental disabilities reside. In the monitoring leading up to that report, DRA determined that there was excessive mechanical and chemical restraint of residents at the facility. DRA included information about this in its January 2015 report.¹ DRA found that the use of restraints was unreasonably high when compared with the other similarly-sized Human Development Centers located in Arkansas. DRA recommended that the Arkansas Department of Human Services take steps to determine the root causes of the excessive use of restraint at this facility and pay particular attention to the behavior plans of those residents who are frequently restrained.

DRA followed up its January 2015 report with further investigation and review of restraint practices at the Booneville HDC. DRA issued a second report on January 2016 regarding the excessive use of restraint at the facility.² DRA found that, in the months following the January 2015 report, the use of mechanical and chemical restraints at Booneville HDC was excessive, was not consistent with the facility’s policies, and was not the product of thorough behavior analysis and programming.

As part of the investigation done for the January 2016 report, DRA reviewed restraint information and identified residents who were repeatedly restrained on a regular basis and for excessive amounts of time at Booneville HDC. DRA then sought further information about those residents. One of these residents was Jane, a 24 year old female who had been placed at the Booneville HDC in 2008 when she was 18 years old, after she briefly resided at the Conway Human Development Center.³

Jane was an individual with Mild Intellectual Disability and several mental health diagnoses, including Bipolar Disorder. Part of Jane’s treatment and habilitation needs included services to address her emotional and behavioral

³ DRA will identify the decedent by the name “Jane” in order to protect her anonymity. In addition, the names of the other parties involved have been redacted.
functioning. Jane was assigned to a Special Treatment Program housing unit at the Hillside House at Booneville HDC for most of her time at the facility.

On April 23, 2015, DRA went to the Booneville HDC to meet Jane and talk with her about her experiences with restraint at the facility. DRA wanted to interview her because from January 2014 to February 2015, Jane had been physically restrained more than 40 times for a total of 36 hours and 49 minutes. DRA was not able to interview Jane. Upon arriving at the facility, DRA learned that Jane had died on February 26, 2015, as a result of choking to death on food.

Due to concerns about the treatment of residents generally and the treatment of Jane specifically, DRA conducted an investigation into the circumstances surrounding her death. DRA’s investigation revealed that not only was Jane the victim of excessive restraint, she also was the victim of dangerous “treatment” that led to the development and implementation of a behavior treatment program that ignored serious medical concerns, including Jane’s known risk of choking and history of seizure episodes that included falling, jerking, and vomiting.

There were both choking and seizure precautions ordered for Jane in the years preceding her death. Those precautions were meant to ensure her safety around food to avoid choking incidents and to provide appropriate action in the event of choking or seizure. Yet these precautions were ignored when a tragic and dangerous decision was made to implement a Behavior Treatment Program that emphasized ignoring any behavior that resembled a seizure because it was believed that Jane was deliberately engaging in the seizure-like episodes to garner attention.

The Behavior Treatment Program for Jane was fatally flawed because it did not acknowledge the conflicts between the choking and seizure precautions required for Jane’s safety and the directive that staff ignore her seizure-like episodes. The Behavior Treatment Program was implemented despite concern expressed by direct care staff to the facility’s Director of Nursing that the Program caused direct care staff to act outside of their qualifications. Ultimately, Jane choked to death because of a disregard for choking and seizure precautions.

Although Jane’s death was not due to a restraint, she did die as a result of the outdated and primitive responses to behaviors used at the Booneville HDC that dangerously combined with a lack of coordination in medical and behavioral
care that left her, and continues to leave other residents, at risk of injury and death. Jane was victim to a dangerous Behavior Treatment Program that ignored serious medical issues and punished her for seeking attention, a normal human need. She was left in the care of direct care staff who were in the untenable position of being instructed to not pay attention to Jane during seizure-like episodes in which she had a heightened risk of choking.

Moreover, as with the excessive use of restraint, the State system charged with oversight and monitoring the treatment and deaths of individuals at the Booneville HDC took only a cursory look at the circumstances leading to Jane’s death, thus failing her in death as in life.

DRA urges the Arkansas Department of Human Services and its Division of Developmental Disabilities Services to immediately take the following actions as a start toward ensuring better care for Booneville HDC residents and avoiding unnecessary deaths of residents like Jane:

- immediately hire an independent expert or group of experts to review and assist in evaluating and improving the treatment and habilitation services provided to Booneville HDC residents;
- obtain an independent, expert evaluation of each Booneville HDC resident to make comprehensive recommendations for their treatment and habilitation needs, including coordination of medical and psychological treatment and safety;
- implement a more rigorous, independent review of treatment decisions, practices and incidents, including deaths; and
- implement the recommendations contained in DRA’s January 2016 report.

Jane’s death at 24 years old was an avoidable tragedy. It is also a warning. Without both adequate collaboration and meaningful review of the practices at Booneville HDC, the unreasonable risks to the safety of the residents will persist.

Tom Masseau, Executive Director
Disability Rights Arkansas, Inc.
Death Investigation Report

On February 26, 2015, Jane, a 24 year old resident of the Booneville Human Development Center (Booneville HDC), was pronounced dead at Booneville Mercy Hospital. Earlier that evening, Jane collapsed, began having seizure-like activity, and vomited on the floor of the TV room of her living unit. By the time she was assessed by medical staff, Jane was lying in her own vomit and spilled cereal and was accompanied by staff members who were ordered not to look directly at Jane while she was experiencing seizure-like activity. Mercy Hospital reported her cause of death as cardiac arrest, seizure, and choking due to food in the larynx. The Arkansas State Crime Laboratory conducted an autopsy and ruled that Jane’s cause of death was “[a]sphyxias due to airway occlusion by food bolus.” In other words, Jane’s airway was blocked by food, and she choked to death.

Disability Rights Arkansas’s (DRA) investigation revealed several serious areas of concern that lead us to conclude that Jane’s death was both avoidable and resulted from the deviation from the standard of care expected of a facility of this type in significant ways.

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4 Disability Rights Arkansas, Inc., is the federally authorized and funded nonprofit organization serving as the Protection and Advocacy System (P&A) for individuals with disabilities in Arkansas. As part of its responsibility under federal law, Disability Rights Arkansas monitors and investigates where persons with disabilities reside to determine whether treatment and resources are fair and humane, including whether residents have been subject to abuse and neglect. Disability Rights Arkansas has not only the authority, but also the obligation to investigate and report these abuses pursuant to: (1) Part C of Title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (the DD Act), 42 U.S.C. 15041-15045; (2) the Protection and Advocacy for Individuals with Mental Illness Act of 1986 (the PAIMI Act), 42 U.S.C. 10801 et seq.; and, (3) the Protection and Advocacy of Individual Rights (PAIR) Program of the Rehabilitation Act of 1973, 29 U.S.C. 794e.

5 Disability Rights Arkansas’ investigation included a review of all available records regarding Jane’s residency and treatment at the facility, applicable policies, procedures and standards, interviews both with Booneville HDC staff and DDS Assistant Director for Quality Assurance, and consultation with a medical expert.
The failures of the facility that combined to cause this tragic event include the following:

- The facility failed to initiate any safe, evidence-based interventions or plans to address Jane’s behavior. The Behavior Treatment Program developed for Jane placed her at increased risk of choking, thereby further jeopardizing her safety; the intervention recommended in that Program directly led to her death.

- There was a lack of adequate communication or careful consideration among medical, psychological, and psychiatric personnel at the facility when recommending a Behavior Treatment Program. Jane’s Behavior Treatment Program required staff to ignore a dangerous situation, exposing her to increased choking risk during seizure-like activity.

- The facility failed to initiate or follow appropriate, adequate choking precautions while Jane was eating cereal. The failure of the staff to follow these precautions as well as the inability of the staff to identify and respond appropriately to a choking incident, led to Jane’s untimely death.

- The Booneville HDC and Arkansas Human Development Center Death Review Committee both conducted reviews of the circumstances of Jane’s death; however, the reviews by both Booneville HDC and the Arkansas Human Development Center Death Review Committee were superficial and concluded without complete information or adequate scope.

This report summarizes DRA’s findings, conclusions, and recommendations based on information obtained as a result of its investigation.
Findings

1. On July 9, 2008, Jane, at eighteen years old, was admitted to the Booneville Human Development Center (Booneville HDC) on a respite basis and was made a permanent resident on July 24, 2008. Before this, Jane was placed at the Conway Human Development Center for less than one year. Booneville HDC Social Services Department, Social History Narrative, December 17, 2014.

2. Shortly before her admission to the Booneville HDC, the Reynolds Intellectual Assessment Scales (RIAS) was administered to Jane and resulted in an IQ score of 44, which was determined to be in the moderate range of intellectual disability. The Vineland Adaptive Behavior Scales, Second Edition (VABS-II) was administered to assess Jane’s adaptive behavior functioning, which resulted in adaptive behavior functioning determined to be in the mild range of intellectual disability. Booneville HDC Psychological Evaluation, , M.S., Psy. Ex. II, July 14, 2008.

3. Based upon the RAIS and VABS-II results from July 2008, Jane’s functioning was determined to be in the mild range overall. Id.

4. At the time of her admission to the Booneville HDC, Jane had been diagnosed with the following: Bipolar I Disorder, Manic; Enuresis; and Mild Mental Retardation. Booneville HDC Medical Review, December 16, 2014.

5. For most of her time at the Booneville HDC, Jane resided in the Hillside House Special Treatment Program housing unit. Individual Program Plan Annual Review, January 27, 2014.

6. Individuals in a Special Treatment Program

Hillside House Entrance
must meet certain admission criteria, including a psychiatric disorder that significantly impairs functioning and a history of challenging behaviors. Booneville HDC Special Treatment Program Description, Revised February 10, 2012.

7. The Special Treatment Programs at the Booneville HDC utilize a differential reinforcement of other behavior (DRO) framework, which is intended to reinforce appropriate behavior as defined by the facility. Id.

8. Residents in the Special Treatment Program earn points for positive behaviors and are awarded reinforcement from one of three levels if meeting the point level required. Id.

9. Residents are eligible for discharge from the Special Treatment Program after meeting exit criteria and are considered for transfer to a lesser restrictive environment at that time. Id.

10. Jane passed away on February 26, 2015, after an incident at the Booneville HDC in which she choked to death. Arkansas State Crime Laboratory Autopsy, 7.

11. At the time of her death, Jane had been a resident at the Booneville HDC for roughly seven years.

12. The Booneville HDC Death Summary identified Jane’s diagnoses as “Mild Intellectual Disability; Antisocial Personality features; Bipolar 1 Disorder, Moderate, Most Recent Episode Manic; Factitious Disorder; Enuresis, Nocturnal and Diurnal; Sinus Tachycardia; Astigmatism; Hyperlipidemia; Constipation; Seasonal Allergic Rhinitis; History of Possible Pseudo Seizures; Anemia of Chronic Disease; Contraception.” Booneville HDC Death Summary, p. 1.

13. The Death Summary identified Jane’s medications as Ativan (prolonged seizure activity); Clozapine (antipsychotic); Haldol (Bipolar Disorder); Multivitamin (Nutritional Supplement); Desmopressin (Enuresis Diurnal); Diastat (prolonged seizure activity); Depakote (mood stabilizer/Seizures); Colace (stool softener), Ferrous Sulfate (Iron Supplement); Lithium
(antipsychotic); Loestrin FE (birth control); Loratadine (Claritin); Nasacort AQ (Seasonal Allergic Rhinitis); Inderal (to decrease her fast heart rate); Simvastatin (Hypercholesterolemia); and, Polyethylene Glycol (bulk laxative). Id.

**Choking Precautions**

14. “Choking Risk Assessments” identify the residents’ likelihood to choke and provide guidance for precautions that aid in ensuring the safety of the resident from choking.


16. On April 26, 2012, Jane had a repeat barium swallow study. Id.

17. Both the 2011 and 2012 barium studies indicated Jane had a delayed swallow with premature spillover. Id.


19. At this time, Jane’s choking risk was assessed at 60% based on:
   a. dysphagia diagnosis;
   b. medication side effects;
   c. mealtime actions and behaviors;
   d. rate of spooning and drinking; and
   e. excessive size mouthfuls. Id.


20. As a result of the choking risk assessment, choking precautions were ordered for Jane, which included chopping all of Jane’s foods, monitoring all meals and snacks, and utilizing weighted utensils and other adaptive
equipment. *Id.* Choking Precautions had been ordered since at least 2013. Physician Order Form, December 20, 2013; *see also* Death Summary, p. 3.


22. The Dysphagia Disorder Screening identified Jane’s eating risks and issues to be taking bites and sips that were too large, being distractible while eating, and slumping. The Screening resulted in a recommendation that choking precautions be continued. Booneville HDC Dysphagia Disorder Survey Narrative Summary, January 31, 2014.


24. On January 31, 2014, the speech pathologist drafted an eating and dining plan to address Jane’s choking risk that included:
   a. monitoring of Jane during all meal times;
   b. ensuring that she sit upright at 90 degrees;
   c. ensuring that she take small bites and sips while eating;
   d. using adaptive equipment, such as a weighted cup, weighted spoon, and wrist weights; and
   e. informing medical staff of any signs or symptoms of aspiration.

25. On December 8, 2014, Booneville HDC nursing staff re-assessed Jane for choking utilizing the same Choking Risk Assessment form used on December 3, 2013. At this time, Jane’s choking risk was scored at 30% based on dysphagia diagnosis, medication side effects, and excessive size mouthfuls. Choking Risk Assessment, December 3, 3013.

26. The December 2014 Risk Assessment did not consider the previous issues that the 2013 Choking Risk Assessment and the 2014 Dysgraphia
Disorder Survey Screening had identified that would put Jane at higher risk for choking, namely mealtime actions, mealtime behaviors, and rate of spooning and drinking. Choking Risk Assessment, December 8, 2014.

27. Furthermore, neither the 2013 nor 2014 Choking Risk Assessments reflect knowledge of or information about Jane’s seizure activity when both identifying and assessing choking risk, though that information is requested as part of the assessment. *Id.* This was a significant omission due to the amplified risk to Jane of choking.

28. The Death Summary reiterated that Jane’s “choking risk was 30% as a result of medication that could affect swallowing, mild Dysphagia disorder and taking excessive size mouthfuls at times,” based on evaluations completed on December 8, 2014. Booneville HDC Death Summary, p. 3.

29. Despite failure to identify seizure activity as part of the choking risk assessment, choking precautions were ordered for Jane and remained in effect until the time of her death. Booneville HDC Medical Review, December 16, 2014. Physician’s Orders, renewed by Dr. [REDACTED] on January 2, 2015.

**Seizures**

30. Jane had a history of seizure-like symptoms that presented as jerking and shaking. Death Summary, p. 2.

31. These episodes were, at times, accompanied by vomiting, urination, falling, and catatonic features. Seizure Report, September 29, 2014; Behavior Reports 2014-2015, discussed individually below.

32. Since at least 2009, Jane had been placed on seizure and choking precautions that included, but were not limited to staff informing the Team RN if any coughing or gurgling sounds occur after eating, as well as if staff observed a wet gurgling sounding voice or any other signs/symptoms of aspiration. Dysphagia Disorder Survey, Narrative Summary, January 10, 2014; Dining Plan, January 31, 2014; Physician’s Orders, January 2, 2015.

34. In the months leading up to her death, Jane suffered injuries due to falls that occurred during seizure-like activity, resulting in lacerations to the head, face, and knees:


   **September 3, 2014:**

   **November 8, 2014:**
   Abrasion to the back of the head from falling during a seizure. (Injury Report, November 8, 2014).

35. Jane suffered additional falls during 2014 that resulted in injuries, though those falls were not attributed to seizures by direct care or nursing staff:

   **December 9, 2014:**
   The Behavior Report states that Jane “had a sudden jerking movement and fell, re-opening an old abrasion on her knee” (Behavior Report, December 9, 2014)\(^6\) The Injury Report accompanying the fall does not document the injury as seizure-related. (Injury Report, December 9, 2014). Jane continued to experience “jerking” and falling, which staff characterized as “attention-seeking.” (Behavior Report, December 9, 2014).

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\(^6\) A Behavior Report completed on December 9, 2014, describes Jane making “jerking motions” and falling to the ground, with no attempts to break her fall. This Behavior Report states that this happened four times and that “staff could feel the muscle type spasms in her arms.” Due to the jerking motions, the Behavior Report states that most of Jane’s lunch was spilled or ended up on the floor. Medical was notified and made two visits to check on her. (Behavior Report, December 9, 2014). The Injury Report that coincided with the Behavior Report mentions that Jane falls, but makes no mention of jerking or spasms. (Injury Report, December 9, 2014).
July 25, 2014:
Staff reported that Jane’s whole body would jerk while she was getting medications from nursing staff. Staff responded to the jerking by telling Jane to stop because staff “thought it was a behavior.” (Behavior Report, July 25, 2014).

- Shortly thereafter, Jane arrived at class, and staff members were told about the previous jerking behavior and were asked to observe for that behavior. Staff stated that, during observations, Jane was jerking. While eating a cracker, Jane’s body jerked causing her cracker to hit the floor. As Jane was later walking to mobile (the van used by the facility for transport), she began jerking. She jerked hard and fell to the ground. Staff stated that she was jerking hard and fast. Jane also began vomiting and breathing heavily at that time. (Behavior Report, July 25, 2014).

- The Injury Report completed for treating Jane’s scraped knee does not document the injury as seizure-related. (Injury Report, July 25, 2014).\(^7\)

36. From July 2014 until February 2015, Booneville HDC staff reported more than twenty incidents in which Jane had seizure-like activity. There were 9 such incidents in the month preceding Jane’s death.

July 25, 2014:
Jane had been exhibiting “jerking” during mealtime. Later, as she was walking to mobile, she began to jerk hard and fell to the ground, vomiting and breathing heavily (Behavior Report, July 25, 2014).

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\(^7\) There were additional Injury Reports completed where Jane’s injuries were attributed to falls, but no Behavior Reports were provided to know the circumstances surrounding those falls.
**August 23, 2014:**
Jane had a seizure lasting at least four minutes, which was accompanied by vomiting (Nurse’s notes, August 23, 2014).

**August 25, 2014:**
Jane had a seizure lasting between four and twelve minutes, which also included vomiting and urine incontinence (Nurse’s notes, August 28, 2014).

**August 29, 2014:**
Jane was “jerking” during breakfast (Behavior Report, August 29, 2014).

**August 29, 2014:**
Jane “jerked” and fell to the ground while working. She was stiff and jerking around on the floor. She then vomited, urinated on herself, and became unresponsive. The incident lasted for twelve minutes (Behavior Report, August 29, 2014).

**September 11, 2014:**
Jane jerked while carrying her tray and fell to her knees (Behavior Report, September 11, 2014).

**September 11, 2014:**
Three similar incidents happened right after while Jane was carrying her second tray of food and while she was attempting to eat and drink (Behavior Reports, September 11, 2014).

**September 11, 2014:**
Jane was observed “jerking” on and off for a ten minute period while in the training area (Behavior Report, September 11, 2014).

**November 29, 2014:**
Jane was “jerking” while eating, which caused her to spill her food onto the floor. The report notes that another “jerking” incident had occurred earlier (Behavior Report, November 29, 2014).
December 9, 2014:
Jane experienced a “sudden jerking movement” that caused her to fall and re-open an old wound. The Injury Report does not list the injury as seizure-related (Behavior Report, December 9, 2014. Injury Report, December 9, 2014).

December 9, 2014:
Jane was walking to lunch when she made a “jerking motion” and fell to the ground. This happened a total of four times. Staff noted that Jane did not attempt to stop her fall at all. Staff also noted that they were able to feel “muscle type spasms in her arms.” Jane’s jerking motions were so bad that staff noted most of her lunch ended up in the floor (Behavior Report, December 9, 2014).

December 10, 2014:
Jane displayed what staff characterized as “unusual behavior,” consisting of slumping to the floor and jerking (Behavior Report, December 10, 2014).

December 10, 2014:
Jane stumbled and fell a number of times while walking to receive medications and made several “jerking” movements. Medical staff instructed her to “stop,” but she continued. Jane continued to stumble while walking to her training area. She fell near her work table. During lunch, she was unable to eat or drink due to jerking movements. She eventually vomited and was taking to medical for observations (Behavior Report, December 10, 2014).

December 10, 2014:
Jane exhibited “jerking” and what staff characterized as attempts to fall down (Behavior Report, December 10, 2014).

February 6, 2015:
Jane was having lunch when she started “jerking.” Staff asked her to stop and clean the floor (Behavior Report, February 6, 2015).
February 17, 2015:
Jane was “jerking” and “twisting” so much that the nursing staff had a difficult time taking her blood pressure (Behavior Report, February 17, 2015).

February 19, 2015:
Jane began “jerking,” which resulted in her dropping food while at lunch. Staff marked Jane’s DRO card for demanding attention/disrupting others (Behavior Report, February 19, 2015).

February 21, 2015:
Jane was “jerking” while eating breakfast, which resulted in her food and drink spilling. Staff marked Jane’s DRO card for demanding attention (Behavior Report, February 21, 2015).

February 23, 2015:
Jane was “making jerking motions,” which made food spill. Staff ignored her. She continued jerking until she “realized staff was ignoring her and she stopped” (Behavior Report, February 23, 2015).

February 23, 2015:
Jane was “jerking” at supper and again during her bath. It was noted that staff ignored the jerking both times (Behavior Report, February 23, 2015).

February 25, 2015:
Jane was at work and “began to appear to have seizures.” She later fell out of her chair and into the floor where she refused to move until the class took a break (Behavior Report, February 25, 2015).

37. On June 3, 2014, Jane saw a neurologist, Dr. [REDACTED]. According to the Death Summary, the neurologist noted that Jane’s seizures were well controlled in the past year and recommended that Jane continue with AED (anti-epileptic drug) regimen. Booneville HDC Death Summary p. 2.
According to Booneville HDC staff, the neurologist was not given Jane’s entire behavioral record; thus, she would not have had access to Behavior Reports, which gave a more thorough and accurate picture of Jane’s seizure episodes.

38. On August 28, 2014, Jane’s seizure-like activity was discussed at a Special Team Meeting. At this meeting, the Team determined that all suspected seizure activity must be documented on a Seizure Report “in order for the neurologist to be fully informed,” and that Jane would see the neurologist the next time she was at the Booneville HDC. Special Team Meeting, August 28, 2014 (emphasis added).

39. According to Registered Nurse [redacted], who provided RN approval for Jane’s Behavior Treatment Program, a seizure report must be completed by a staff member for every documented seizure. This system is in place in order to ensure that the facility has an accurate and complete clinical picture for its residents. According to the Registered Nurse, if a staff member describes an incident as a “seizure” in a behavior report, then there must be a seizure report completed as well.

40. Booneville HDC staff did not follow the directive to document all suspected seizure activity on a Seizure Report form for Jane. For the twenty episodes of jerking or suspected seizure activity described above, staff completed only three seizure reports for Jane. See Seizure Reports, August 29, 2014; September 3, 2014; September 29, 2014.

41. On October 28, 2014, Jane had an Electroencephalogram, (EEG). The EEG report stated as follows:

No epileptiform activity was seen (although its absence does not necessarily exclude the presence of an underlying clinical seizure disorder). The presence of mild intermittent slowing of the background may also represent a mild encephalopathic process although this particular finding was very subtle and mild. Further clinical correlation is recommended.

Death Summary, p. 2.

42. On November 4, 2014, Jane saw the neurologist again. According to the Death Summary, the neurologist “noted a history of seizures, most of the
jerking reported sound like pseudo seizures, continue present AED regimen approach jerking episodes with non-attention [...].” Death Summary, p. 2.

43. Following the EEG, the neurologist recommended continuing Jane’s anti-epileptic drug regimen. Death Summary, p. 2-4.

44. Jane continued to have physician orders for at least two medications to be administered during seizures lasting longer than five minutes. Medical Review, December 16, 2014; Physician’s Orders, October 1, 2014.

45. Jane’s mother does not recall being told that Jane was somehow faking seizures to gain attention. She said that she was frequently called by facility staff and told that Jane had a seizure. She was aware that Jane frequently fell down, sometimes hurting herself, and that this was reported to her as the result of seizures.

46. Jane’s mother was concerned about the cause of the seizures that her daughter was having. She requested that the facility consider reducing the amount of medication that Jane was taking, due to concern about whether the medications were causing seizures.

47. Orders for Jane continued to include “Seizure and Choking Precautions.” Death Summary, p. 2.

48. Jane’s records include research regarding each medication and interactions between medications. Several of Jane’s medications, either alone or in combination with other medications prescribed to her cause “loss of seizure control or symptoms such as tremors, poor muscle coordination, increased seizures, and changes in behavior.” Other combinations cause “confusion, fainting, fast heart rate, drowsiness, drooling, difficulty breathing, [...] dizziness, lightheadedness, fainting, and/or changes in pulse or heart rate.” See Drug Interaction Report, Received by BHDC Records Room December 17, 2014.

49. On December 12, 2014, Jane saw a psychiatrist, Dr. [ ] . According to the Death Summary, the psychiatrist reported “[s]tate somewhat
improved, Jerking episodes likely pseudo seizures, possible side effect from meds orthostatic hypotension- decrease Clozapine [...] and added diagnosis for Factitious Disorder.” Death Summary, p. 2.

50. According to the DSM-V Manual, there are four diagnostic criteria for Factitious Disorder:

a. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
b. The individual presents himself or herself to others as ill, impaired, or injured.
c. The deceptive behavior is evident even in the absence of obvious external rewards.
d. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.\(^8\)

51. Unfortunately, it does not appear that there was investigation into the underlying cause of the identified problem for Jane. Instead, the seizure activity for Jane was assumed to be attention seeking misbehavior to be ignored. Causes of nonepileptic seizures can include migraines, panic attacks, sleep disorders, or psychologic distress, according to the American Academy of Family Physicians.\(^9\)

**The Behavior Treatment Program**

52. Jane had a history of significant behavioral symptoms as part of her disabilities. Since at least March 2012, Jane had some form of Behavior Treatment Program. See Behavior Treatment Program, March 12, 2012.

53. The primary behavioral symptoms that Jane’s Behavior Treatment Program indicated needed to be monitored were “Physical Aggression,”

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54. The Behavior Treatment Program noted that Jane “thrives on personal attention.” Id.

55. Over the years, Jane’s Behavior Treatment Program consisted primarily of Differential Reinforcement of Other Behavior that allowed Jane to earn rewards from a Reinforcement Menu. Id.

56. DRA initially encountered Jane’s case in conjunction with examining the restraint practices of Booneville HDC as a whole. Jane was frequently restrained by staff, spending over 36 hours in restraints over the course of the thirteen months preceding her death.

57. A few of the behavioral incidents that DRA reviewed for Jane were:
   - In September 2014, after Jane was restrained for 1.5 hours on a papoose board, a staff member recommended weekly formal counseling for Jane to help her cope with personal issues. Behavior Report, September 18, 2014. There is no record of Jane ever receiving the counseling recommended by the staff member.
   - In November 2014, Jane was administered a dose of Haldol for chemical restraint without any explanation. Although there is a chemical intervention checklist (provided to the physician for evaluation of whether chemical intervention should be permitted) there was not an accompanying behavior report. The intervention checklist states that the client did not present a clear and present danger to others at that time, nor did the client present a clear and present danger in the hour preceding the evaluation. Nevertheless, the facility administered the dose of Haldol. Chemical Intervention Checklist, November 19, 2014.
   - In December 2014, Jane was cited for “non-compliance” when she was yelling that she wanted her mommy during class and acting like she was asleep. When staff told her to work, she swung at
staff and tried to kick or stomp on the staff members’ feet. She was restrained on a papoose board for a half hour and told staff afterwards that she would “be good tomorrow and not listen to the voices she was hearing in her head and she misses her mom.” Again, no recommendations were provided by staff to prevent future restraints. Behavior Report, December 8, 2014.

- In January 2015, Jane was strapped to a papoose board after refusing to eat her dinner. Staff encouraged her to eat and she left the room. When staff tried to get her back to the dining room, she became aggressive. It was not until after Jane had been restrained for just under an hour that staff gleaned from her that her grandfather had recently died and she missed him. When staff reviewed Jane’s restraint on this date, they determined that there were no recommendations to prevent a restraint from occurring in the future. Behavior Report, January 18, 2015.

58. There is no indication that Jane’s treatment was altered to address the September 2014 recommendation for formal counseling or that Jane had a formal plan for professional psychological counseling in the year preceding her death.

59. On December 17, 2015, Jane’s Interdisciplinary Team requested changes to the Behavior Treatment Program to include interventions for Factitious Disorder symptoms. Behavior Treatment Program, January 6, 2015, p. 1.

60. On January 6, 2015, the Behavior Treatment Program was modified to provide that:

Factitious Disorder is a condition where Jane purposely feigns illness or causes injury to herself. The methods of illness falsification can include exaggeration, faking, and actual self-harm. Her symptoms include jerking, twitching, shaking to the point where food falls off eating utensils, stumbling, and falling down. The primary functions of the symptoms appear to be avoidance of tasks and
attention seeking. Jane has verbalized that she had a seizure, then later stated she had faked it. Jane has fallen down without attempting to catch herself, and injured herself. Jane may also demonstrate physical aggression towards others, tantrum behaviors, verbal aggression, noncompliance, running out of an assigned area, and argumentativeness.

Even though her pseudo seizure symptoms may be attention seeking, with high risk behavior there is always the potential for accidental self-harm. Jane usually begins this behavior by jerking or twitching. When attention is given, the behavior typically escalates to increased motor movements, stumbling and/or falling to the ground. If Jane makes any threats, gestures or actions to hurt herself, follow BHDC Suicide Precautions Policy or Increased Supervision Policy.

Behavior Treatment Program, January 6, 2015, pp. 2-3 (emphasis added).

61. Jane’s Behavior Treatment Program went on to describe Factitious Disorder Interventions as follows:

This serious illness requires a delicate balance of providing appropriate intervention, but not reinforce the symptoms. Staff should ignore jerks and twitches and monitor these behaviors using peripheral vision (avoid watching her directly). Jane may continue this behavior despite planned ignoring. If Jane is working in a training area and attempts to stand up, or walk off, direct Jane to sit back down. If she complies, provide praise for following staff instruction. Should she refuse to comply and runs, or continues walking, escort her back to a seated position. If Jane complains of an inability to engage in a task due to pseudo seizures, redirect her attention to something positive or about expectation with active treatment tasks. This redirection may serve to provide Jane with the attention she is seeking in a positive manner and reduce her tendency to seek negative attention.

Behavior Treatment Program, January 6, 2015, p. 3.

62. The Behavior Treatment Program recognized that there was a

“serious potential for self-harm [...] when Jane is exhibiting pseudo seizure
behaviors” and required interventions such as, “ignore jerks and Twitches and monitor these behaviors using peripheral vision [ . . . ] instruct her to get up and continue to her destination.” Behavior Treatment Program, January 6, 2015, pp. 3-4 (emphasis added).

63. On January 8, 2015, the modified Behavior Treatment Program was approved by Booneville HDC Superintendent and Janet Campbell, RN. Behavior Treatment Program Approvals for January 2015 Behavior Treatment Program.

64. On January 30, 2015, Jane’s guardian provided consent to the modified Behavior Treatment Program. Consent for Behavioral Treatment, January 30, 2015.

65. The January 2015 Behavior Treatment Program required staff to ignore Jane’s seizure-like activity due to the diagnosis of factitious disorder. See Behavior Treatment Program, January 6, 2015; Physician’s Orders, January 2, 2015.

66. Physician’s Orders for Jane continued to require seizure and choking precautions to be followed. There was a significant conflict between the Behavior Treatment Program and Physician’s Orders that was not reconciled before Booneville HDC staff were required to implement the new Behavior Treatment Program.

67. For Jane’s January 2015 Behavior Treatment Program, Psychological Examiner, (Examiner) provided training for eleven staff members on February 12, 2015, and followed with training for approximately fifty more staff members on February 13, 14 and 17, 2015. A video of the February 12, 2015, training was then played for approximately 150 more staff for training purposes.

68. The training provided by Examiner consisted of her sitting at a table and reading the Behavior Treatment Program to staff and briefly discussing its contents. The video was then played for other groups who were not present for the initial training. The training did not include any discussion
of how to resolve the conflict between the Behavior Treatment Program’s requirement to ignore seizure-like activity and the seizure or choking precautions.

69. In an interview with Examiner, DRA asked about the incidents in which Jane vomited during seizure-like episodes. Examiner told DRA that she did not know that Jane had ever vomited during seizure-like activities and would have included such information in the Behavior Treatment Program if she had known.

70. DRA consulted with Dr. Kevin Ann Huckshorn, an expert in facility practices. Dr. Huckshorn expressed grave concerns regarding both the implementation and maintenance of the Behavior Treatment Program adopted by Booneville HDC.

71. Dr. Huckshorn identified a need for qualified personnel to identify not only the behaviors for the Program to address but also whether the Program is effective. In Jane’s case, seizure-like activities increased after implementation of the Program, signifying to Dr. Huckshorn that the Program was not effective and should have been discontinued. The ineffectiveness of the program was either not reported to the persons charged with evaluation of the Program’s effectiveness or was reported and not properly evaluated.

72. Finally, Dr. Huckshorn cited a significant deviation in the standard of care in requiring direct care staff to assess Jane’s seizure episodes and distinguish between a behavior that mimics a medical emergency and an actual medical emergency, all of which are outside the scope of their training, education, and experience.

Jane’s Death

73. Jane was pronounced dead at 9:14 p.m. on February 26, 2015. The events leading to her death are as follows:

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10 Dr. Huckshorn is a licensed and certified mental health nurse and substance abuse clinician with 36 years of experience working in a variety of public and private behavioral health organizations. She has published on topics including violence, treatment adherence, trauma-informed care, and workforce development and has co-authored a book with William Anthony, PhD, titled “Principled Leadership in Mental Health Systems and Programs” (2008).
February 26, 2015, 7:30 p.m.:

Jane was in the TV room of the Hillside House Down having an evening snack of Fruit Loops cereal and milk.\textsuperscript{11} Residential Care Shift Supervisor [REDACTED] (Supervisor) saw Jane “in the TV room eating her snack [when] all of a sudden she jerked really big with her whole body, spilling her cereal.”\textsuperscript{12} Supervisor later said that Jane spilled her cereal and milk before eating any cereal.\textsuperscript{13}

Supervisor responded to Jane by asking her “to clean up her mess.”\textsuperscript{14} She advised Jane to do this because this was Supervisor’s understanding of Jane’s modified Behavior Treatment Program to address behavioral symptoms of Factitious Disorder.\textsuperscript{15} Jane then walked down the hallway to a linen closet to get a towel.\textsuperscript{16}

Supervisor initially reported that Jane, after returning to the TV room, “got down on her hands and knees and fell over in a big jerking movement.”\textsuperscript{17} Supervisor later reported that Jane “got down on her hands and knees and began wiping up her mess.”\textsuperscript{18} She also reported that Jane asked if she could

\textsuperscript{12} Supervisor Statement February 26, 2015 (Supervisor 1), p. 1.
\textsuperscript{13} Supervisor 2, p. 1.
\textsuperscript{14} Supervisor 1, p. 1.
\textsuperscript{15} Supervisor 2, p. 1.
\textsuperscript{16} Supervisor 2, p. 1.
\textsuperscript{17} Supervisor 1, p. 1.
\textsuperscript{18} Supervisor 2, p. 1.
have another snack, and when Supervisor told her that they were not going to discuss this at that time, Jane “jerked really big again and fell over.”

Supervisor asked Jane to get up and sit in the chair, which she did. At that time, there were several other residents in the TV room.

7:33 p.m.:

Supervisor left the TV room to call the nurse to get some pain medication for another resident. (LPN), the LPN who took Supervisor’s call for medication, reported this call from Supervisor as 7:35 p.m.

When Supervisor returned to the TV room, “Jane was in the floor, her whole body jerking as if in a seizure.” Supervisor again asked her to get up and sit in the chair. Jane did not respond and “only kept jerking.” Also, at that time, Jane “started throwing up liquid/flem.”

Supervisor then “left Jane alone but kept watching her.” Supervisor later stated that she did not leave her alone in the TV room but “stood watching/monitoring her actions.”

After about 30 seconds, Supervisor yelled down the hall for another staff member, , Residential Care Technician (Technician), who was in

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19 Supervisor 2, p. 1.
21 Supervisor 1, p. 1.
23 Supervisor 1, p. 1.
24 Supervisor 1, p. 1.
25 Supervisor 1, p. 1.
26 Supervisor 1, p. 1.
27 Supervisor 1, p. 1.
28 Supervisor 2, p. 2.
another resident’s room. She asked Technician to stay with Jane while Supervisor went to call Medical. Technician does not mention this event at all in her statement.

“At this point Jane’s eyes were still open. She had finished vomiting, and she had stopped jerking. She was breathing loud raspy breaths....” This was something that Supervisor had witnessed at least two times when she previously witnessed Jane having a seizure.

7:39 p.m.:

Supervisor called Medical a second time and spoke to LPN. In her first statement, Supervisor reported that she told LPN that Jane “had fell out into a seizure and that she was throwing up.” In her second statement, Supervisor reported that she told LPN that Jane “was having a pseudo seizure and that she had thrown up liquids.” Supervisor was not sure if LPN “needed to check [Jane.]”

LPN confirmed that Supervisor told her that “we need you to come check Jane after her seizure.” LPN reported that “Jane has pseudo seizures as determined by medical staff and protocol mandates observing client and providing safety for client.”

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29 Supervisor 2, p. 2.
30 Supervisor 2, p. 2.
31 Statement of Technician, February 26, 2015.
32 Supervisor 2, p. 3.
33 Supervisor 2, p. 3.
34 See Supervisor 1, p. 1; Supervisor 2, p. 3.
35 Supervisor 1, p. 1.
36 Supervisor 2, p. 3.
37 Supervisor 2, p. 3.
Supervisor reported that LPN told her that she would be over to check Jane in a few minutes.\textsuperscript{40} LPN reported that she left for Hillside House Down immediately.\textsuperscript{41}

Supervisor then returned to the TV room\textsuperscript{42}, sat in a chair and watched Jane who was lying on the floor.\textsuperscript{43} At this time, Supervisor believed Jane was still breathing because she could see her stomach moving up and down.\textsuperscript{44} Jane’s eyes were open.\textsuperscript{45}

Supervisor wiped the vomit from Jane’s face, nose, and hair.\textsuperscript{46} She also checked Jane’s mouth to “to ensure there was nothing in it.”\textsuperscript{47} She rolled Jane over onto her back and shook and called out to her.\textsuperscript{48} Jane did not respond.\textsuperscript{49} Supervisor “assumed she was ignoring me because that’s the way she did after every other pseudo seizure event” Supervisor witnessed.\textsuperscript{50} Supervisor got up and sat in a chair, leaving Jane on the floor on her back.\textsuperscript{51}

Supervisor was not certified to perform CPR on the date of Jane’s death. In fact, her certification lapsed more than one year prior, on February 22, 2014.

\textsuperscript{40} Supervisor 2, p. 3.
\textsuperscript{41} LPN 2, p. 1.
\textsuperscript{42} Supervisor’s hand-drawn diagram of the scene in which these events took place is attached as Appendix A.
\textsuperscript{43} Supervisor 2, p. 3.
\textsuperscript{44} Supervisor 2, p. 3.
\textsuperscript{45} Supervisor 2, p. 3.
\textsuperscript{46} Supervisor 2, p. 3.
\textsuperscript{47} Supervisor 2, p. 3.
\textsuperscript{48} Supervisor 2, p. 3.
\textsuperscript{49} Supervisor 2, p. 3.
\textsuperscript{50} Supervisor 2, pp. 2-3.
\textsuperscript{51} Supervisor 1, p. 2.
7:42 p.m.:

LPN arrived at the TV room in Hillside House Down. She did not check on Jane first but instead gave another resident medication. All the other residents left the TV room, leaving only LPN, Supervisor, and Jane.

LPN checked on Jane, who was still lying on the floor in the middle of the TV room on her back with her head to the right side. Meanwhile, Supervisor was sitting in a chair “directly across” from Jane.

LPN checked Jane’s mouth and did not find any foreign objects or vomit in her mouth; however, she saw “clear vomitus” around Jane. She also saw whole dry cereal on the floor.

LPN “observed [Jane] per protocol following seizure like activity.” LPN at first thought that Jane was breathing based upon “feeling [Jane’s] breath on [her] hand.” Jane’s eyes were open.

LPN sought more information from Supervisor. LPN reported that Supervisor told her “Jane had her cereal in hand and began throwing up.” Supervisor also told LPN that “Jane had one of her seizures [sic] like episodes and fell
forward dropping her cereal.” LPN asked Supervisor whether any cereal had been eaten. Supervisor reported none had been eaten.

While LPN was talking with Supervisor, Jane’s breathing ceased. LPN “got on the floor beside [Jane] to check for her pulse and indications of breathing.” Jane did not have any blood pressure or pulse.

LPN began chest compressions. After around 30 compressions, LPN asked Supervisor to take over with chest compressions so she could call for an ambulance, and Supervisor started chest compressions. LPN then took over chest compressions while Supervisor called for assistance from additional staff.

7:50 p.m.:

Residential Care Technician (Technician2) was upstairs at Hillside House when he heard someone scream for help and ran downstairs. Technician2 reported that he was asked by LPN to call by radio for an Automated External Defibrillator (AED) which he did. This was at the same time that Technician was trying to call by radio for an AED.

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63 LPN 2, p. 2.
64 LPN 2, p. 2.
65 LPN 2, p. 2.
66 LPN 1.
67 LPN 2, p. 2.
68 LPN 1.
69 LPN 2, p. 2.
70 LPN 2, p. 2.
71 LPN 2, p. 2.
72 Technician2 Statement February 26, 2015 (CD).
73 CD.
74 Supervisor 2, p. 5.
7:52 p.m.:

LPN called [redacted], (LPN2), and requested additional medical assistance at Hillside House Down because Jane was “down and non-responsive.” After she called for LPN2, LPN again took over doing chest compressions on Jane. After she did another 30 compressions, LPN then retrieved the breathing mask for rescue breaths. When she did this, she noticed that there was no rise in Jane’s chest or return of breath. LPN again checked for obstructions but did not find any.

7:57 p.m.:

Residential Care Assistant, [redacted], (Assistant), a First Responder, brought a portable suction devise to the TV room and attempted to suction without success.

7:58 p.m.:

LPN2 arrived; LPN observed LPN2 call for an AED.

8:00 p.m.:

Residential Care Staff [redacted] (Staff) arrived at the TV room with an AED. Assistant proceeded to place the AED pads on Jane; however, the AED never
provided an instruction to shock “because the heart rhythm showed asystole.”

Various staff members continued to do CPR and chest compressions while waiting for the ambulance to arrive.

8:20 p.m.:

The ambulance arrived at the Booneville HDC. EMS were informed that “the patient was eating and started having a seizure and fell to the floor and went into cardiac arrest.” EMS personnel took over care, continued chest compressions, and transported Jane to Mercy Booneville Hospital.

9:14 p.m.:

Jane was pronounced dead by Dr. , Booneville HDC’s staff physician.

Post-Mortem

74. On the night of Jane’s death, a Booneville HDC staff member called her mother at about 9 p.m. Jane’s mother was told that her daughter had died earlier that night. Her mother was upset and shaking, trying to understand what she was being told. She remembers that she was told that her daughter was eating cereal during snack time, had a seizure, fell to the floor, and choked to death on the cereal.

75. Jane’s mother later asked if there was any “tape” or recording of what happened to Jane. There are no video cameras at the Hillside House

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83 Death Summary, p. 4.
84 Statement of Assistant, undated.
85 Logan County EMS Record, p. 3.
86 Logan County EMS Record, p. 1.
87 Logan County EMS Record, p. 1.
88 Death Summary, p. 4.
where Jane was at the time of the incident. Booneville HDC did not advise her mother of any investigation into Jane’s death and did not provide her with additional information, including the death investigation report.

76. The final diagnosis from the Hospital was “Cardiac arrest, Seizure, Choking due to food in Larynx.” Death Summary, p. 4.

77. On March 1, 2015, the State Crime Laboratory issued an autopsy report on Jane’s death. The conclusion of the report was that the cause of death was “Asphyxia due to Airway Occlusion by Food Bolus.” Autopsy Report, p. 1.

78. The Autopsy Report noted that Jane’s “stomach contained approximately 200 mL of partially digested food fragments and tan liquid. There was [sic] large food fragments present, some measuring up to 3 cm in greatest dimension.” Autopsy Report, p. 3.

79. The Autopsy Report’s Findings included, among other things, the following:

II. Clinical history of dysphasia
   A. Witnessed choking episode
      i. Large food bolus removed from airway reported by emergency medical personnel
      ii. Microscopic food particles present in lungs

Autopsy Report, p. 7.

80. The Autopsy Report’s Opinion was as follows:

This 24 year old female, [Jane], dies due to asphyxia due to airway occlusion by food bolus.

According to investigative reports provided by the Logan County Sheriff’s Office and the Booneville Human Development Center, [Jane] was witnessed to be consuming a bowl of cereal when she had a pseudo seizure associated with choking and vomiting. Emergency services were summoned and a large food bolus was removed from [Jane] airway. She was transported to a local hospital where she was pronounced dead.

Autopsy revealed a well-developed, well nourished, adult female with no internal or external evidence of traumatic injury. There was no evidence of significant natural disease.
At the time of autopsy, there was some freshly masticated food fragments within the airway, but the airway was not occluded at autopsy. Microscopic examination of the lung tissue revealed the presence of food fragments with no evidence of actual inflammatory reaction.

Autopsy Report, p. 7 (emphasis added).

**Review of Jane’s Death by Booneville HDC and DHS**

81. Jane’s death was investigated by Booneville HDC. Upon learning of the possible death at 8:18 p.m. (two minutes before the ambulance arrived), the administrator of Booneville HDC, ordered (Investigator) the on-call Social Service Worker to begin taking statements. See Report of Investigator, March 5, 2015.

82. Investigator’s investigation involved questioning each of the witnesses, including follow-up with Supervisor and LPN after having received their written statements. Investigator noted that “[t]he only inconsistency I found in the [Behavior Treatment Program] is when it specifies behaviors to expect, and vomiting is not mentioned.” Investigator concluded that staff followed the plan, and she did not scrutinize the care Jane received beyond that conclusion. She did not acknowledge or note the choking precautions Jane was under, nor did she consult with a physician regarding whether a patient who exhibits vomiting during seizure-like activity should be ignored.

83. Investigator was also the Social Service Worker on duty at Booneville HDC the day prior to Jane’s death. That day, Investigator recorded an incident wherein Staff told Investigator that Jane said that the voices in her head were telling her to kill herself. After consulting with Examiner, they planned to put Jane on suicide precautions, involving “enhanced supervision and 15 min. documented checks,” to continue through the next morning. Jane’s mother wanted to call Jane and check on her after learning about Jane’s suicidal comments, but Booneville HDC staff told her to only speak with staff. Case Notes, February 25, 2015.
84. The Arkansas Department of Human Services Office of Long Term Care appears from their records to have only investigated the incident by reviewing the Investigator’s report. There is no meaningful review of the events prior to Jane’s death.

85. Arkansas Department of Human Services is required to convene a Human Development Center Death Review Committee (Death Review Committee) for the purpose of reviewing all deaths at HDCs to determine (1) the circumstances surrounding the death; (2) the appropriateness of the medical and nursing care rendered by the HDC; and (3) any HDC system issues that may require review and resolution for quality improvement and quality assurance. The Death Review Committee is charged with ensuring that the HDCs operate in compliance with conditions and standards imposed by the Arkansas Medical Assistance Program.

86. Death Review Committee members are given packets upon which they base their review. The packets are required to contain:

   a. Interdisciplinary discharge summary including medical discharge summary;
   b. A copy of the incident (IRIS) report of the death and any incident reports prior to the death that were related to the death;
   c. Nursing notes for one month prior to the date of death;
   d. Physician orders and progress notes for one month prior to the date of death;
   e. Most recent MAR and lab reports within the last month, prior to death;
   f. Most recent physical examination;
   g. Medical diagnostic reports (X-ray, CT scan, MRI, etc.) within the month prior to death;
   h. Most recent Individualized Program Plan;
   i. Death Certificate; autopsy report, if available; and
   j. Verification of guardianship.
87. Although they are charged with scrutinizing the policies of the HDCs to determine whether there should be a policy change, the HDC Death Review Protocol does not require the HDC to forward the written policies to the HDC Death Review Committee.

88. According to the Assistant Director for Quality Assurance within DHS, while it is not a written policy or part of the protocol, the Death Review Committee saves no account of what was received or reviewed by the committee, other than a single “Conclusion Statement” detailing their findings. Every other record of what the Death Review Committee received or reviewed from the HDC is promptly destroyed following the meeting of the Death Review Committee. Thus, there is no opportunity for meaningful review of their decision.

89. In Jane’s case, the “Conclusion Statement” consists of a single page. There is no mention of the conflict that existed between the choking and seizure protocols and her Behavior Treatment Program. In fact, there is no mention of her Behavior Treatment Program at all in the HDC Death Review Committee Report; accordingly, there is no way to verify whether the order to ignore Jane during seizure activities was ever considered by the Death Review Committee.

90. There also is no indication that the Death Review Committee reviewed the policies of the Booneville HDC as part of its review of her death.

Critical Information Not Considered as Part of Booneville HDC or the Death Review Committee

91. DRA interviewed some of the employees who were present during Jane’s death and during the implementation of Jane’s Behavior Treatment Program.

92. Supervisor reported concerns about Jane’s Behavior Treatment Program to the Director of Nursing prior to Jane’s death. According to

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89 A copy of this Conclusion Statement is attached hereto as Appendix B.
90 The Director of Nursing mentioned in this report is no longer employed by Booneville HDC.
Supervisor, the Director of Nursing told her that all of Jane’s seizures are faked behaviors and that she should ignore them as directed unless it is a medical emergency. Supervisor was uncomfortable having to distinguish between a medical emergency and seizures that she was told were behaviors.

93. LPN, who was the first medical assistance to arrive at the TV room in response to the call for help, suspects that Jane was already deceased when she arrived on the scene. She believes that, in retrospect, she was probably mistaken regarding her immediate assessment that Jane was breathing when she arrived, as there was a large food bolus that prevented her from breathing. The LPN reported that LPN staff are not notified of the specifics of patients’ Behavior Treatment Programs, as they do not have the constant contact with the patients that the direct care staff have.

94. Examiner, who wrote the 2015 Behavior Treatment Program for Jane, blamed the psychiatrist and neurologist for the suggestion of ignoring Jane’s seizures. When asked whether she considered how to distinguish between seizures that coincided with vomiting and those that did not, she reported that she knew of no incident in which Jane exhibited vomiting as part of a seizure activity, and would have included such a distinction in the Behavior Treatment Program if she had known.

95. Examiner indicated that the medical staff had the opportunity for input in that area and did not note a conflict. However, she confirmed that Behavior Treatment Programs do not rescind medical orders. Yet the January 2015 Behavior Treatment Program for Jane contradicted longstanding medical orders for her, including both choking precautions and a seizure protocol.

96. The Behavioral Treatment Program was developed without comprehensive medical, psychological, and behavioral information about Jane and without adequate coordination of care between disciplines. The resulting inconsistency between reaction to choking or seizures versus reaction to factitious disorder created an unreasonably dangerous environment for Jane.
97. Inconsistent and contradictory treatment directives passed down from medical and psychology staff created an environment where direct care staff members were left in the untenable position of having to make judgment calls which they were not qualified to make. There is no evidence that members of Jane’s direct care staff were given instruction on how to reconcile these two contradictory directives. This demonstrates a lack of communication and coordination between departments in client programming.

98. “Ignoring” is overused at Booneville HDC. Dr. Huckshorn notes that the overuse of “ignoring” implies permission for the staff to fail to engage residents who they deem to be misbehaving. Further, ignoring escalating behavior is not best left to staff who do not have the education, training, or experience to know when to respond to an emergency, as opposed to ignore a behavior.

99. The practice of internal investigation of colleagues is not a productive or meaningful practice within the HDC. In this instance, Investigator was only charged with the duty of ensuring that staff followed the directions that were in place. Thus, there was neither an effort to scrutinize the directions nor to inquire into the conflict that existed between the Behavior Treatment Program and Physician’s Orders. Investigator even acknowledged the valid point that vomiting is not mentioned in the Behavior Treatment Program, and yet further investigation on this point was quickly dismissed.

100. The HDC Death Review Committee is required to investigate and examine (1) the circumstances surrounding the death; (2) the appropriateness of the medical and nursing care rendered by the HDC; and (3) any HDC system issues that may require review and resolution for quality improvement and quality assurance.

101. The HDC Death Review Committee process and review of Jane’s death was superficial. It does not appear that the HDC Death Review Committee goes beyond review of the facts of the sentinel event. In this case, the Death Review Committee did not indicate whether they reviewed Booneville
HDC policies, the apparent conflict between the Behavior Treatment Program and the Physician Orders, or the requirement that the direct care staff act outside of their education, training, and experience in implementing the Behavior Treatment Program.

**Conclusions**

1. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to ensure comprehensive neurological evaluation and the type of clinical correlation recommended for Jane to ensure adequate assessment of her seizure-like episodes.

2. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to comprehensively or completely assess Jane’s choking risk by not considering her seizure-like episodes in the 2013 or 2014 choking assessments.

3. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to ensure that medical needs related to Jane’s risk of choking and required choking precautions were addressed in her 2015 Behavior Treatment Program, thus creating an unreasonably dangerous plan for Jane that led to her death.

4. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to assess and determine the impact of the multiple medications administered to Jane, several of which include seizures or seizure-like activity as a side effect.

5. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to ensure comprehensive psychiatric and/or psychological evaluation of and treatment for Jane to determine and treat the underlying causes for the Factitious Disorder diagnosis.
6. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to ensure that Jane had a Behavior Treatment Program that could be safely implemented by direct care staff, thus creating an unreasonably dangerous plan for Jane that led to her death.

7. It does not appear from the evidence in the records that there was meaningful collaboration in developing Programming for Jane at Booneville HDC. While the departments are all represented at interdisciplinary meetings, the events leading to Jane’s death signify a lack of meaningful collaboration.

8. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to provide Jane with the active treatment required, including the failure to conduct an adequate or comprehensive assessment of her behavior, and to use evidence-based methods to address her behaviors and their causes.

9. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC adopted a punitive approach to Jane’s needs, including her identified need for attention, and overreliance on “ignoring” as a behavioral intervention at the facility.

10. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC otherwise failed to adequately or appropriately address Jane’s behavior needs by allowing for the overuse of mechanical and chemical restraints in response to her behaviors.

11. The State of Arkansas Department of Human Services and its Division of Developmental Disabilities Services have failed to ensure that there was an adequate or meaningful investigation into Jane’s death, and that a system is in place to ensure such investigations. The failure to examine the medical and psychological treatment, as well as the omissions, in the development of the Behavior Treatment Program led to a cursory, superficial review of Jane’s death.
**Recommendations**

1. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should immediately hire an independent expert or group of experts to review and assist in evaluating and improving the treatment and habilitation services provided to Booneville HDC residents, including coordination of medical and psychological treatment and safety.

2. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should provide improved direct (as opposed to video) training and support for direct care staff.

3. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should retain an independent expert with expertise in working with facilities to implement a more rigorous, independent review of treatment decisions, practices, and incidents, including deaths.

4. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should provide and require participation of Booneville HDC’s senior administrative, clinical, and direct care staff in comprehensive training on person-centered and trauma-informed, recovery-oriented, evidence-based services and supports.

5. The Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and Booneville HDC’s senior administrative and clinical staff should be required to develop a strategic plan to transform this institution to one that adopts current, best practice philosophy, vision, and values. This plan should be updated monthly and reviewed quarterly by the state office or an external entity.

6. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should ensure that residents of Booneville HDC have access to active treatment, including the provision of mental health and other treatment that supports residents in addressing their challenging behaviors in ways that do not include coercion or punishment.

7. The Arkansas Department of Human Services and its Division of
Developmental Disabilities Services should implement the recommendations included in DRA’s January 2016 Report.
Arkansas State DHS Mortality Review Committee

RE: Conclusion Statement from 06-25-15 Committee Meeting

was admitted to Booneville Human Development Center (BHDC) on July 23, 2008. She was residing at Hillsdale House Down, ext. 1486, until her demise on February 26, 2015 at Mercy Booneville Hospital.

had diagnoses of mild intellectual disability; Antisocial Personality features; Bipolar I Disorder, Moderate, most recent episode Manic; Factitious Disorder; Enuresis; Nocturnal and Diurnal; Sinus Tachycardia; Astigmatism; Hyperlipidemia; Constipation; Seasonal Allergic Rhinitis; History of possible Pseudo Seizures; Anemia of Chronic Disease; Contraception.

On 2/26/15 [redacted] LPN received a call at 7:39 p.m. from the living area staff reporting, [redacted] was about to eat her snack of cereal, Fruit Loops, and started having seizure like activity. They needed a nurse to come check her. [redacted] LPN arrived to find [redacted] with her head turned to the side, clear emesis/vomitus surrounding client and no seizure activity. The nurse checked [redacted]'s mouth for foreign object/vomitus, her mouth was clear of foreign object. [redacted] was breathing at this time.

[redacted] LPN observed her per protocol following seizure like activity. [redacted] became still, breathing ceased. Staff attempted to obtain pulse and blood pressure with manual Bp cuff but could not get either pulse or blood pressure. The nurse and staff began CPR. Staff members continued compressions while the nurse called for an ambulance at 7:50 p.m.

[redacted], a direct care staff member, who is also a First Responder, responded with a portable suction device and attempted to suction without success. [redacted] LPN checked [redacted]'s mouth for obstruction again due to not being able to force a breath, nothing was visualized. The nurse called for assistance of the other nurses, [redacted] LPN and [redacted] LPN at 7:52 p.m. Staff continued to attempts to give breaths and do chest compressions.

At 8:00 p.m., the Program Supervisor arrived with the AED and it was placed on [redacted]. The AED did not instruct to prepare for shock because the heart rhythm showed asystole, staff continued CPR.

Logan County Sheriff's office reports the EMS arrived to BHDC at approximately 8:25 p.m. and took over care and continued chest compression, transporting her to Mercy Booneville Hospital. Code Blue was run/CPR continued. She also was intubated. Dr. [redacted] and nurse, [redacted], RN arrived at 9:10 p.m.

[redacted] was pronounced dead at 9:14 p.m. The Final Diagnosis from the hospital was Cardiac arrest, Seizure, and choking due to food in the Larynx. At 9:50 p.m., Dr. [redacted] and the nurses returned to BHDC and notified [redacted] family of her death.

After review of the information submitted by Booneville Human Development Center, it is the consensus of the committee that standard of care was met at BHDC. There are no recommendations.

Respectfully submitted,

LaToya Bankhead-Sims, DHS/DDSS HDC Liaison, QA

Date of Committee Approval: 8/27/15

MRC Conclusion Statement (s) June 25, 2015